

A New Diagnosis in Psychiatry, the Acute Organic Change of Character (AOCC). This is One Case Report and Description, of which there are Several in Hospitals Worldwide

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Abstract

Objective: The concept of organic mental disorder is a complex set of cognitive, emotional and behavioural disorders. There are syndromes in which the impairment of the highest cognitive functions is constant and outstanding, and there are other syndromes in which accessory symptoms predominate (perception, thought, mood and personality). We consider that, although this last group of disorders is less prevalent, the vast majority of these syndromes are misdiagnosed. Our aim is to propose a new denomination to gain specificity and rigor in the characterization of this clinical condition. We introduce the Acute Organic Character Change (AOCC).

Methods: A case report from our clinical experience at the Consultation and Liaison Psychiatry in the Hospital Clínic of Barcelona. A review looking for the current state of psychiatric diagnosis related to organic mental disorders and a discussion focusing on whether or not adding a new diagnosis may be useful.

Results: The AOCC evidences the close interrelationship that exist between biological aspects and complex behaviours and attitudes that are called "personality".

Conclusion: By introducing this diagnosis we will bring conceptual clarity to our current classification allowing us to apply a more rigorous diagnosis and, most importantly, a therapeutic approach to these states.

Keywords: Neurocognitive Disorders; Neurobehavioral Manifestations; Personality disorders

1. Introduction

The concept of organic mental disorder is a complex set of cognitive, emotional and behavioural disorders that originate in the disturbance of the function and/or structure of the brain tissue. DSM-IV eradicates the term organic, since it wrongfully implies that "non-organic" mental disorders lack a biological basis, and groups them into three sections: 1) delirium, dementia, amnesic disorder, and other cognitive disorders; 2) mental disorders due to medical illness; and 3) substance use disorders. Despite the wide spectrum of psychopathological manifestations present in these organic mental disorders, all of these have been defined based on their most frequent symptoms and what best defines them, namely the cardinal/essential symptom. On the one hand, there would be syndromes in which the impairment of the highest cognitive functions, like consciousness, memory, attention are constant and outstanding, such as DELIRIUM, DEMENTIA or AMNESTIC DISORDER, and on the other hand, the syndromes in which the cognitive dysfunctions are minimal or difficult to ascertain, with predominance of other symptoms such as perception, thought, mood and personality [1]. These include ORGANIC PSYCHOSIS, ORGANIC PERSONALITY DISORDER OR ORGANIC ANXIETY SYNDROME. From our clinical experience at the Consultation and Liaison Psychiatry in the Hospital Clínic of Barcelona, we consider that, although it is true that this last group of disorders is less prevalent the vast majority of these syndromes are misdiagnosed due to 3 factors: firstly, many of their symptoms are similar to those of the primary psychiatric disorders classified in other sections of the DSM (affective disorders, psychotic, anxious, ...) and are often confused with them ; secondly, sometimes is difficult to consider that they are a direct physiological consequence of organic alterations, which are often subtle, and do not correspond to the examples given by medical and psychiatric literature (postictal psychosis in an epilepsy, depression related to pancreatic head cancer). Therefore they could not be attributed to the underlying medical illness; and thirdly some syndromes do not meet the standardized criteria of their Axis I or Axis II homonymous. For example, organic personality disorder is based on a change in an individual's behaviour or attitude that is persistent and unalterable over time, as would be the prototypical Axis II disorder that any patient might have. But, what about a change in the individual's general behaviour or attitude, which is shown to be closely associated with or caused by an underlying organic process, and which is rapidly resolved when the organic noxious agent is eliminated? Why has this organic brain syndrome not been recognized? Does this type of clinical manifestation not exist? We believe that it does, and we will try to expose it in the next real clinical case.

2. Case Report

A middle age patient is admitted to the Trauma Service due to an epiphyseal-metaphyseal fracture awaiting surgery. The psychiatric background consisted of being followed by psychologists in 2014, with the diagnosis of adjustment disorder with mixed anxiety and depressed mood, due to cancer recurrence. In the initial interview no psychopathological alterations were found. However, 72 hours after admission, we were asked to urgently assess the patient because of altered behaviour. On examination, initially presented a self-pitying attitude, with mood swings dependency and disillusionment that was abruptly interrupted by ideations of self-injury with impulsive rage without the existence of evident external events that were factors that triggered the episode. This behaviour was inappropriate and disproportionate, showing lack of coping flexibility, with a predominance of unpredictability and

impulsiveness. An extreme emotional response with feelings of inferiority was observed, despite demonstrable evidence of self-competence. The cognitive functions remained preserved, but presented a capricious cognitive style, with cognitive-affective ambivalence, experiencing rapid changes with fluctuation in perceptions or opposing thoughts with difficulty in evaluating reality. These included interpretations of everything that had happened up to that moment with high subjectivity and the tendency to over-attribute hostile intentions to others, all of which was unusual in his/her habitual character, as reported by the relatives. In addition, the patient was able to reason about his/her medical situation and the future of the disease, but in terms that the relatives did not recognize as typical of the patient. Olanzapine 5mg was administered with ad integrum restitution of the episode about 20 hours after its onset. The patient was dismayed and ashamed of what had said and done, with regret and adequate distance from the episode, and was unable to identify any triggers for said state. The patient's clinical course was carefully reviewed, and a febrile peak with microcytic anaemia was observed 48 hours before the onset of the episode. The patient received a transfusion of two red blood cell concentrates, which ended eight hours before the abrupt onset of the reported psychopathological syndrome. Acute Stress Reaction and organic mental disorder were considered as differential diagnoses.

3. Discussion

Although the diagnosis of Acute Stress Disorder would be correct in this case, since it is a disorder that contemplates the response to a physical or psychological factor with remission in hours or days, we must make a wideranging differential diagnosis. In our experience, there are many mental alterations secondary to transitory physiological alterations that are codified as acute emotional reactions, underestimating the importance of "the organic" in their appearance. In this case, we find hypoperfusion [2], and the abnormal body temperature [3] as physiological precipitants of the failure of the brain system. The therapeutic relevance is immense. In the first case, a psychotherapeutic approach will be attempted to help the patient to face, accept and overcome the "psychological trauma". The symbolic event, no matter if it may have been generated, either physically, such as the suffering of a serious illness, or mentally, such as the communication of bad news will be healed through psychotherapy.

While in the second case, an attempt will be made to reverse the pathological organic process affecting brain metabolism [4], which underlies the change of character (an hyponatremia, an infection, ...) with specific treatment [5, 6]. In order to determine whether the symptoms are a direct physiological consequence of another medical pathology, there are several considerations to guide this diagnosis. For example, one factor is the presence of a temporary association between the onset, exacerbation, or remission of the medical condition and the altered mental state. However, a review of current classifications has been performed and there are no clinical criteria coding for acute personality changes secondary to medical condition. The diagnosis of personality change due to another medical condition is included under the heading of personality disorder. Its essential characteristic is to be persistent and the phenomenology of change is indicated by the subtypes listed in the diagnostic criteria. The most common manifestations are affective instability, lack of impulse control, outburstsof aggression or totally disproportionate anger. This symptomatic pattern causes clinically significant discomfort or deterioration in important areas of functioning, which supports the aspect of chronicity already mentioned with the word "persistent". So, should

clinical psychiatrists be content to apply "other specified mental disorders due to another medical condition" category to those presentations in which the symptoms characteristic of a mental disorder predominate, but which do not meet the criteria for any specific mental disorder, and which are also attributable to a medical condition? Our stance is "no". In addition, we should use accurate diagnoses to gain specificity and the utmost rigor in the characterization of diseases that emerge from the brain. Our proposal for this clinical condition is that we should use the denomination "Acute Organic Character Change"(AOCC). We support the idea that the incomplete state of the current literature is not related to psychopathological ignorance [7] but to the difficulties in validating clinical syndromes such as AOCC, which to date we consider to be underdiagnosed and therefore underreported [8]. Conceptually we are describing an alteration of the subject's way of being, or behaviour, with the preservation of cognitive functions and the level of consciousness as well as the state of attention, which would let us differentiate it from the acute confusional state. Therefore, we are dealing with an acute-onset syndrome that does not depend on emotional or psychological factors, such as acute stress disorder, nor is it persistent as in personality disorders, and that does not affect cognitive functions, consciousness or attention. The AOCC evidences the close interrelationships that exist between biological aspects and complex behaviours that are called "personality" and that can be altered in an acute, transitory and subtle way, due to a physiological alteration, and needs as a treatment, the restitution of the underlying biological alteration. We believe that there is a gap concerning what we consider AOCC. By introducing this diagnosis into clinical psychiatric practice, we will bring conceptual clarity to our current classification of psychiatric diseases [9], allowing us to apply a more rigorous diagnosis and, most importantly, a therapeutic approach to these states, with the final benefit for our patients.

Conflicts of Interest

None.

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